Ca Patient's 'Unexplained' Fever Laid to Infection

Medical Tribune Report

WASHINGTON—Unsuspected and difficult to diagnose infection, often of fungal etiology, may explain "unexplained" fever in cancer patients, investigators from the Division of Infectious Diseases at Indiana University School of Medicine, Indianapolis, told the 15th Interscience Conference on Antimicrobial Agents and Chemotherapy sponsored by the American Society for Microbiology.

Important clues to the presence of infection are the type of neoplasm, the granulocyte count and clinical or laboratory abnormalities indicating specific organ involvement, they suggested.

"While many neoplasms are capable of causing fever without the presence of infection, cancer patients often have compromised immune mechanisms, either by virtue of their disease or because of therapeutic agents used in treatment, which tend to make them more susceptible to opportunistic infections," said Dr. Friedrich C. Luft, head of the research team.

Patient Acutely Ill

He and Drs. J. Peter Rissing, Arthur White, and Geo. F. Brooks, evaluated the causes of fever of unexplained origin (FUO) in 36 cancer patients seen during a 30-month period. Sixteen patients had lymphoma, 12 leukemia, and eight solid tumors.

Each patient met certain criteria: a diagnosis of malignant neoplasm documented prior to fever onset; fever of at least three weeks duration; fever higher than 38.3 degrees centigrade on several occasions; and an uncertain diagnosis after one week in hospital.

"These criteria served to exclude patients with fever due to self-limited viral infections and those with bacterial infections responsive to antibacterial therapy," Dr. Luft explained. "These patients were acutely ill. They had persistent fever in spite of antimicrobial therapy with combinations of antibiotics which included gentamicin, cephalothin and carbenicillin."

The research team anticipated that the majority of patients selected would prove to have fever secondary to neoplasms. "This did not occur," declared Dr. Luft. "Minimally, 50 per cent of our patients had infections. And it was not possible to rule out the presence of infection with absolute certainty in patients who had fevers presumably due to their neoplasms."

Fungi were the cause of infection in nine of the 18 infected patients. Histoplasmosis was found in three patients, candidiasis in three and aspergillosis, systemic sporotrichosis and cryptococcal meningitis in one patient each.

"This reflects the increasing importance of fungi as a source of infection in patients with compromised body defenses," noted Dr. Luft.

Six patients had unresolved pyogenic infections, one had tuberculous pericarditis, and two had viral infections.

In the 18 apparently noninfected patients, fever appeared associated with some change in the neoplasm, according to Dr. Luft. "Five of the six patients with solid tumors had noted new masses or swellings and lymphoma patients often had newly enlarged lymph nodes," he said.

While the infected and noninfected group of patients had a number of features in common, for example age and sex distribution and mean duration of fever, several distinguishing parameters were noted.

"Absolute granulocyte counts were strikingly different for the two groups," said Dr. Luft. "In infected patients, marked granulocytopenia was evident. Eleven patients in this group had absolute granulocyte counts of less than 1000/mm³ and five others less than 3000/mm³.

"In contrast, few of the noninfected patients had granulocytopenia. Only one patient in this group had a granulocyte count of less than 1000/mm³."

Type of neoplasm also distinguished infected from noninfected patients, according to Dr. Luft. All 12 leukemia patients had infection.

Morphologic Exams

Morphologic examination of biopsy or aspiration specimens, with cultures, was the most productive diagnostic measure, the research team concluded. "In infected patients, likely sites for productive biopsy procedures were clinically apparent. These included pulmonary infiltrates visible on chest roentgenograms or abnormalities detected on physical examination. There was a paucity of abnormalities indicating organ system involvement with infection in the other 18 patients.

"Regardless, physicians' diagnostic efforts should not be deterred in such patients," Dr. Luft continued. "Repeated thorough evaluations for infection are warranted."

Dr. Luft stressed, however, that diagnostic measures must be tailored to the individual cancer patient. Noting that a large number of aggressive procedures were done in the apparently noninfected patients, he said: "These patients were able to withstand major diagnostic efforts whereas the often moribund infected patients could not. In the latter instances, the physician and patient together must decide whether surgical diagnostic procedures and potentially toxic antimicrobial therapy will prolong useful life or make dying difficult."

A Med Trib 41

Medical Tribune and Medical News

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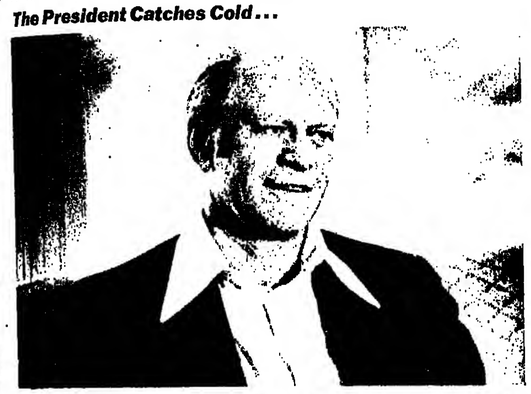
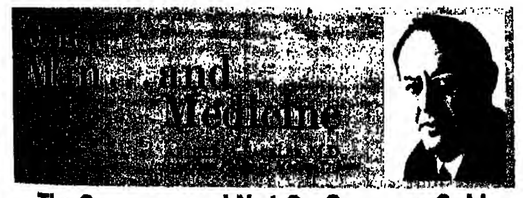
Vol. 16, No. 41 *world news of medicine and its practice—fast, accurate, complete* Wednesday, November 19, 1975

The President Catches Cold...



...and Recovers Uneventfully, a sequence of clinical events that has a particular moral for practicing physicians. Please see Dr. Sackler's column below and Dr. Lasagna's letter on treatment of colds in the adjacent columns.



The Common and Not-So-Common Cold

I SHOULD HAVE DONE SOMETHING about this before.

Last year, in fact more than a year ago, I received a letter from an expert whose expertise and judgments have always been, for me, a source of respect and admiration—Louis Lasagna, Professor of Pharmacology, University of Rochester School of Medicine and Dentistry. Of all subjects, it was on the "common cold." I must plead guilty to failing to act sooner on his communication. I do act now, and will try to make up for my default. In exculpation of my guilt, I have asked the editor of MEDICAL TRIBUNE to publish his letter in several issues. You will find Dr. Lasagna's communication in the adjacent columns.

Misuse of Antibiotics?

Why do I bring this up now? It is not just that winter "is-a-comin' in." A number of relevant developments have occurred in the interim. Attacks on the medical profession by government officials, including top doctors in F.D.A. and H.E.W. continue. Prominent among the charges of professional incompetence is the indictment that practicing physicians are misusing antibiotics for the "common cold."

Are the colds for which physicians prescribe really "common colds?" It would appear from Professor Lasagna's letter that one rarely finds a "common cold" in the doctor's office, but rather "uncommon colds."

Now the scene shifts from Mar. 27, 1974, the date of Professor Lasagna's letter, to October of this year, 1975:

President Ford Catches Cold

This was news. Ron Nessen, the White House Press Secretary, issued statements; the wire services buzzed; radio, TV and newspapers throughout the country carried the reports.

The nation was "assured" (that word was used again and again) that it was only a "head cold." According to the *New York Times*, **"Mr. Nessen assured reporters the President was suffering from nothing more serious than the lingering effects of a head cold Mr. Ford has been trying to shake."**

Clearly it was not pneumonia.

The *Times* continued, quoting the President's spokesman, **"It's just not possible to tell how long it will take him to recover from the cold."**

Clearly, it was not pneumonia.

We were informed, "The illness was

Continued on page 3

Meditation ... Without Metaphysics

Before you plunk down $125 for a course in transcendental meditation, try the simple, no cost, "nonocultic" relaxation technique devised by Drs. Herbert Benson, Sidney Alexander and Charles L. Feldman of Boston's Harvard Medical School and Beth Israel Hospital and the Worcester Polytechnic Institute in Worcester, Mass. Although the technique has not been broadly applied, the authors reported in *Lancet* (August 30) that it "seemed to decrease the frequency of P.V.C.s in most pa-

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HEW Considering Network of Centers For Amniocentesis

By FRANCES GOODNIGHT
Medical Tribune Staff

WASHINGTON, D.C.—The first full-scale prospective study of amniocentesis performed for prenatal diagnosis has shown that the procedure is both safe and accurate, according to a summary of results made public here by the National Institute of Child Health and Human Development which sponsored the research.

The findings, based on second-tri-

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60 Per Cent Success

Microsurgery Reverses Vasectomies

By NATHAN HORWITZ
Medical Tribune Staff

SAN FRANCISCO—A new microsurgical technique for reversing vasectomies has resulted in a 60 per cent success rate in early studies, a San Francisco urologist reported here at the annual meeting of the American College of Surgeons.

Challenging the widely-held view that fertility may be permanently damaged by an immune reaction to the original vasectomy, Dr. Sherman J. Silber said the preliminary data for the new procedure, developed concurrently by himself and an Australian investigator, showed that 17 of the first 30 patients have impregnated their wives, and that "sperm in the ejaculate of the vast majority of patients are good."

The poor results of other reported vasovasostomies, Dr. Silber declared, stemmed from inadequate surgical procedures, "not [from] sperm-agglutinating and sperm-immobilizing antibodies in the vasectomized patient."

"Our studies indicate that the major impediment to the successful reversal of vasectomy is the quality of the re-

Continued on page 14

Dr. Lasagna Writes on Colds and Antibiotics

March 27, 1974

Dear Arthur:

One of the most constantly raised points in the current discussion about overprescribing of drugs is the alleged prescribing at a spinal reflex level of antibiotics for "the common cold." It is repeatedly said that in surveys of doctors in practice, a very high percentage of patients who come to the doctor's office for "the common cold" receive an antibiotic.

On the face of it, this seems reprehensible. On reflection, however, it occurs to me that most patients do not visit a doctor's office, and pay good money, for advice about uncomplicated coryza. I suspect, instead, that most patients with upper respiratory complaints go to see doctors suffering from a combination of cough, stuffed nose, post-nasal drip, swollen glands in the neck, earache, etc.—in other words, from secondary bacterial complications of the common cold. If this is the case, then the prescribing of an antibiotic is not wrong; rather, the question is only: what antibiotic would be best?

I ask that you print this letter in Medical Tribune to solicit from your readers some facts bearing on the statements I have just made. If I am wrong, then the doctors of this country deserve the severe criticism they are receiving from many quarters at present. If I am right, then the doctors are practicing good medicine, and it is the critics who deserve disapproval.

Louis Lasagna, M.D.

Abnormal Erythrocyte Aging Found in Preleukemic State

Medical Tribune Report

CHICAGO—A prospective study of the preleukemic phase of myelomonocytic leukemia in 270 suspected patients at the Mayo Clinic has revealed a number of previously unreported findings in 33 patients who later progressed to overt acute nonlymphocytic leukemia.

Dr. Robert V. Pierre, who began the study in 1968, said the most striking new feature in bone-marrow studies of the preleukemic phase in these patients was "abnormal erythrocytic maturation, specifically megaloblastoid maturation."

Dr. Pierre, who is Associate Professor of Internal Medicine and Laboratory Medicine at the Mayo Clinic and Hospital, Rochester, Minn., reported his findings to a joint meeting here of the American Society of Clinical Pathologists and the College of American Pathologists.

Atypical megakaryocytic morphology in the bone marrow was also common in the 33 patients, he noted, as well as "abnormal granulopoiesis with left-shifted maturation and a slight increase in blasts, nuclear cytoplasmic maturation dissociation, and monocytoid features". Marrow hypoplasia was also much more common than previously reported, Dr. Pierre said.

Patients in the Mayo study were entered on the basis of "unexplained cytopenias or other combinations of findings described in previous studies as suggestive of preleukemia."

Myelomonocytic leukemia, he explained, is a nonlymphocytic acute leukemic process involving all of the myeloid cell lines. The very frequent monocytic appearance of the granulocyte is another characteristic of the overt phase.

Of the 270 patients originally involved, only 131 are still living. In addition to the 33 who did develop leukemia, four "suspects" have become normal, seven developed "a characteristic chronic myeloproliferative syndrome, in particular, agnogenic myeloid metaplasia," and 19 have cytogenetic abnormalities.

Besides the new findings, the study strongly indicated that suspected patients who show cytogenetic abnormalities "have an extremely poor prognosis, even if acute leukemia does not supervene," Dr. Pierre commented.

Hematologic findings included anemia in all 33 patients, leukopenia in 18, thrombocytopenia in one third of the patients, and a combination of immature granulocytes and nucleated red cells in 13, Dr. Pierre said.

Most Common Abnormality

The most common abnormality in red blood cell morphology was oval macrocytosis, he noted. "In addition to the preponderance of patients with macrocytic anemias [not due to B-12 or folate deficiency], an additional seven patients had dimorphic peripheral blood pictures with oval macrocytes and hypochromic microcytic red cells."

One Man... and Medicine

ARTHUR M. SACKLER, M.D.,
International Publisher, Medical Tribune

The Common and Not-So-Common Cold

Continued from page 1

the first of Mr. Ford's Presidency, and White House officials sought to provide assurance that it was minor."

Let us now seek to reconstruct the case from reliable press sources. The Chicago Tribune Press Service noted that **"Ford had been coughing for about a week, Nessen said, before he telephoned Dr. William Lukash, his personal physician, Sunday afternoon."** President Ford played two sets of tennis Sunday afternoon and then took a nap. Nessen said, **"His cold was worse when he awoke, so he called Lukash and asked him to stop by after dinner."**

Dr. Lukash did so. He **"noted the fever and added an antibiotic to his prescribed medical regimen, which had included a nasal spray and cough medicine. Lukash, a Navy rear admiral, also suggested that the President sleep late Monday and curtail his activities."** This was done.

By Monday White House Press Secretary Ron Nessen said, **"Overall, the President is feeling reasonably well except for sinus congestion, a tendency to cough, and a temperature slightly above 100 degrees."**

The President's recovery apparently has been uneventful since then. There have been no reported antibiotic side effects, such as sensitivity reaction, development of resistant organisms, etc. He simply recovered and returned to work.

Prescription for the President

Now, let us take another look . . . one of the most powerful men in the world was sick. What to do? What was done was reported . . . the President of the United States was given an antitussive for his cough, a nasal spray presumably for sinus congestion, and—great heavens!—an antibiotic for his respiratory tract infection, reassuredly not for pneumonia. Apparently the President's physician acted like the good physician he is. Probably the only thing additional we would have done would have been to put him on a regimen of high dosages of Vitamin C.

But just a moment! Was the organism cultured? What was found? We were reassured that it was a "head cold"—no reported identification of a specific bacterial infection. From the sequence of events it appears that the physician to the President of the United States acted like most competent practicing physicians—not like an "armchair medical general" far from the scene of patients' homes or physicians' office, far from clinic or hospital.

Questions Needing Answers

What will happen now? Will the President's physician be open to censure by a PSRO committee? Where were the experts from our Communicable Disease Center? Where were our F.D.A. officials? What will the effect of Dr. Lukash's actions be on his malpractice premiums? Is President Ford's physician now open to a potential malpractice suit because he may have defied the injunctions of F.D.A. officials, package inserts and assorted experts?

It would appear that Professor Louis Lasagna in his 1974 communication was right in his suspicion that *"most patients with upper respiratory complaints go to see doctors suffering from a combination of cough, stuffed nose, post-nasal drip, swollen glands in the neck, earache, etc.—in other words, from secondary bacterial complications of the common cold."*

I think that Professor Lasagna is deserving of the replies he seeks from physicians in the practice of medicine whom he addressed at the end of his letter:

"I ask that you print this letter in MEDICAL TRIBUNE to solicit from your readers some facts bearing on the statements I have just made. If I am wrong, then the doctors of this country deserve the severe criticism they are receiving from many quarters at present. If I am right, then the doctors are practicing good medicine, and it is the critics who deserve disapproval."

Until we hear from you, out there, may I close with a heartfelt observation:

What's good enough
for the President of the United States
is good enough for our patients,
the citizens of the United States.

For Cervical Dysplasia in Fertile Women: Cryosurgery

Medical Tribune Report

PHILADELPHIA—The use of cryosurgery in management of young women with dysplasia of the cervix who want to retain their childbearing potential was advocated here at a National Conference on Gynecological Cancer held by the American Cancer Society.

Dr. Paul B. Underwood, Jr., of the Medical University of South Carolina, said no serious complications had occurred in 64 patients receiving this treatment on an outpatient basis after combined investigation by colposcopy and biopsy had shown noninvasive cervical epithelial atypicality.

Of the group, 29 have been followed for more than a year post-therapy and all but two of the 29 have continued to maintain negative cervical cytology when examined at three-month intervals, Dr. Underwood reported.

The women represented a sizable percentage of the 317 patients who have been referred to the university's colposcopy clinic because of an abnormal Pap smear since the establishment of the clinic late in 1972.

Visualization Important

Those considered for cryosurgery included 73 women desirous of having a child (or additional children) as well as one elderly woman whose medical condition precluded surgery. In 10 cases, however, colposcopic examination was believed inadequate because the endocervical canal could not be visualized fully, and these women were treated by cold knife conization.

Dr. Underwood stressed the importance of adequate visualization of the endocervix, specifically of the upper border of the lesion. He also warned against reliance on colposcopy alone to classify the degree of dysplasia.

"It cannot be overemphasized," he said, "that colposcopy must be combined with biopsies of the exo- and endocervix before attempting cryosurgery."

Management of the 64 patients included a repeat Pap smear, colposcopy, and then cryosurgery using the double-freeze technique with a refrigerant of Freon or nitrous oxide. All patients were treated on an outpatient basis without analgesia or anesthesia and none required discontinuance of the procedure because of pain.

'Far More Economical'

Patients were kept in the supine position for 10 minutes and then permitted to dress and resume normal activities. They were told to wear either an external or internal pad, and advised to abstain from intercourse for 10 days.

Such treatment is "far more economical" than therapy by cold knife conization, Dr. Underwood pointed out. At his institution, charges for cryosurgery have been $35 compared to an approximate cost of more than $730 (covering the two days of hospitalization, anesthesia charges, physician's fee, etc.) incurred for the cone procedure.

The gynecologist said that questions have been raised about therapy of mild dysplasia, since many women regress to normal without treatment. But, he continued, findings from a number of studies indicate that the majority do not, and many progress to more serious atypicalities.

For this reason, and because the term "abnormal Pap smear" has such disturbing connotations for patients, Dr. Underwood believes a benign procedure such as cryosurgery is advisable even though the recurrence rate of dysplasia in treated women can be expected to increase with the length of follow-up.

Meningococcal Vaccines

Medical Tribune Report

CINCINNATI—Meningococcal group A and C polysaccharide vaccines are now being manufactured here by Merrell-National Laboratories under F.D.A. licensure. At present, the vaccines are destined only for military personnel or other adults at high risk.

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CLINICAL NEWS NOTE: *"Our studies indicate that the major impediment to the successful reversal of vasectomy is the quality of the reanastomosis and that a non-strictured vasovasostomy can only be accomplished with confidence by microsurgical operating techniques."* (Dr. Sherman J. Silber, Assistant Professor of Urology, University of California School of Medicine, San Francisco. See page 1.)

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Circulation audited by Business Publications Audit of Circulation, Inc.

MEDICAL TRIBUNE is published each Wednesday except on April 30, July 9, July 30, Aug. 13, Oct. 29 and Dec. 21, by Medical Tribune, Inc., 880 Third Ave., New York, N.Y., 10022. Controlled circulation postage paid at Vineland, N.J. 08360 Subscription $25.00, Students $7.50.

Infection Control

Interhospital Spread of Gram-Negatives a Potential Threat

By ANASTASIA TOUFEXIS
Medical Tribune Staff

WASHINGTON—Interhospital spread should be considered a potential source of nosocomial gram-negative rod infections, Dr. Dennis R. Schaberg, of the Center for Disease Control (CDC) in Atlanta, advised members of the 15th Interscience Conference on Antimicrobial Agents and Chemotherapy sponsored here by the American Society for Microbiology.

"Interhospital spread has been recognized in the past as a serious cause of infection, especially of gram-positive Staphylococcus aureus," Dr. Schaberg told MEDICAL TRIBUNE. "However, it has not been recognized as often for gram-negative organisms and is perhaps more common than we think. But the potential for spread is there. These pathogens can be carried from hospital to hospital by transferred patients or by personnel common to many facilities."

Dr. Schaberg, a member of CDC's Bureau of Epidemiology, was called in, for example, to investigate an outbreak of Serratia marcescens in a Nashville, Tenn. hospital. A preliminary review revealed that the outbreak had initially occurred at another facility, Dr. Schaberg said. Before the field investigation was completed, the infection had spread to two more hospitals.

Serratia marcescens, a pathogen which seems to occur only in hospitalized, compromised patients, has been recognized over the last ten years as a serious, if uncommon, cause of infection and often death, he said.

Four Hospitals Involved

"Between April 1973 and December 1974, 210 patients in four geographically separate hospitals in Nashville were infected with Serratia marcescens resistant to all currently available parenteral antibiotics," Dr. Schaberg told the meeting, speaking for Drs. Walter E. Stamm, Robert A. Alford, William Schaffner and John V. Bennett of the CDC and the V.A. Hospital and Vanderbilt University School of Medicine in Nashville. "Twenty-one patients had bacteremia and there were eight infection-related deaths."

"Actually, we were rather lucky, if I can use that word, that the organism was so resistant," Dr. Schaberg told MEDICAL TRIBUNE. "Too often, interhospital spread of gram-negative organisms goes unnoticed. But we noticed this one right away because the pathogen was so unusual."

The initial outbreak occurred in April 1973 in the large intensive care area of one facility, said Dr. Schaberg in recapitulating the progress of the epidemic. "A total of 18 patients were infected. In all except one, the infection was of the urinary tract and catheter associated. The outbreak lasted through June 1973."

Another hospital reported an isolate of S. marcescens in October 1973 but the nature of the problem was not evident until February of 1974, Dr. Schaberg continued. "By that time, the organism was no longer confined to one area," he said. "It appeared on all medical and surgical wards."

In February 1974 an outbreak occurred in a third Nashville hospital but was confined to two intensive care units. A fourth hospital reported infections in five patients in one intensive care unit in December of 1974.

"The serotype (O):H7) and phage type (186) of the epidemic strain were identical in all four hospitals, with background serratia strains yielding a variety of other serotypes." Dr. Schaberg noted.

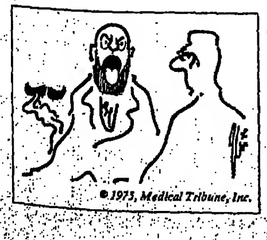
Identifying the Source

In trying to identify a common source, the investigators first looked for a single medication, solution or device, but found none. "Then we looked for a patient transferred from one hospital to another," said Dr. Schaberg. "This remains a possibility although we were unable to find confirming evidence.

"However, we did recover the organism from the hands of personnel, a large number of whom were common to the four hospitals. This suggested passive carriage as the mode of transmission between hospitals."

Infected patients were treated either with amikacin, a new experimental drug, or a syngergistic combination of colistin and trimethoprim sulfa, said Dr. Schaberg. "Infection has been eliminated from two hospitals and the number of infections in the other two has decreased.

"But in the absence of truly effective therapy, prevention must be stressed," Dr. Schaberg declared. "This involves better catheter care, handwashing and aseptic technique. And also more restricted use of broad spectrum antimicrobial therapy."



. . . brief summaries of editorials or comments in current medical and scientific journals.

Focus on Hepatitis

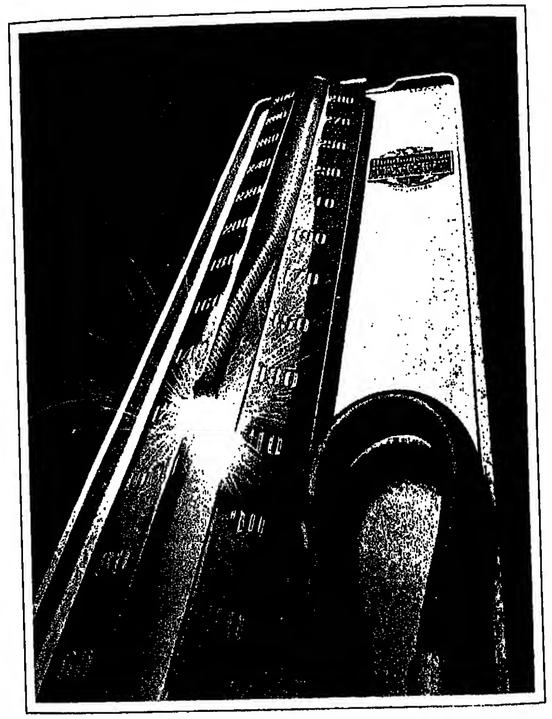
"Although the recent advances in viral hepatitis are heartening, they also bring into sharper focus a new problem. The new tests for HAV [hepatitis A virus], combined now with various tests for detection of HBV [hepatitis B virus] infection, have afforded substantiation of the claims that a high proportion of transfusion-association hepatitis is caused by as yet unidentified infectious agents, neither HAV nor HBV. Feinstone and co-workers recently studied 22 patients each of whom had an episode of transfusion-associated hepatitis negative for HBs Ag [hepatitis B surface antigen], HBc Ag [hepatitis B core antigen] and the respective antibodies to these antigens. Antibody response to HAV was measured by immune electron microscopy. None of the 22 patients developed serologic evidence of HAV infection. Whether such unidentified infectious agents are also important causes of hepatitis in human populations at large will require much study. Nevertheless, it is evident that the more is learned about viral hepatitis the more appears to remain unknown." *(Editorial, Shalom Z. Hirschman, M.D., West. J. Med. 123:224, Sept., 1975).*

Surgical Learning . . .

". . . Another current phenomenon in surgical learning in community hospitals might be called the "residency crisis." (After a number of years of preparation and warning, the disapproval of surgical residency training in many community hospitals seems to be under way.) It is quite apparent that free-standing community hospital surgical residency programs, that is, those without strong medical school affiliations, will soon become extinct. . . .

". . . Survival of a community hospital residency in the immediate future will require, in addition to the absolute sine qua non of meaningful medical school affiliation, 1) a full-time director, 2) demonstrable ability to attract American trainees, 3) clear evidence that resident learning (as opposed to resident service) is the focus of the program, and 4) regular documentation of specialty board certification by graduates of the program. Not all of these requirements are, at present, part of the written policy of residency approval bodies, but they seem nonetheless obvious. Nor it is difficult to defend them. Those community hospitals in which the issue of the future of the surgical residency still exists must decide . . . whether they can and should meet these requirements . . .

"Stamford Hospital surgeons have found themselves very much involved in the issues touched upon here, and we cannot claim to have solved them . . . We are trying to learn from others . . . We hope that our progress in learning will reflect favorably on our profession and on the care of our patients. *(Editorial, Gerald O. Strauch, M.D., Conn. Med. 39:543, Sept., 1975).*



First Month Found 'Critical Period' in Patient Compliance

Medical Tribune Report

DALLAS, TEX.—A study of patient compliance in 89 persons with ocular hypertension has indicated that the decision to treat strongly influences compliant behavior, and that the first month after initial diagnosis is "the critical period" in determining compliance or noncompliance.

Reporting to the American Academy of Ophthalmology and Otolaryngology here, Dr. John F. Bigger, Associate Professor of Ophthalmology at the Medical College of Georgia, Augusta, said 37 patients (33 per cent) were lost during the 12-to-20 month follow-up. Of these, 26 dropped out within one month of diagnosis.

Patients were selected on the basis of "intraocular pressure of 22 mm Hg or higher, with asymptomatic ocular pressure abnormalities." The 20 patients with glaucomatous visual field defects and 21 of the remaining 69 with normal visual fields were treated, he said; the remaining 48 went untreated. Records were then studied about one year later to determine how many patients were maintaining regular follow-up.

Treated Groups Rate Better

"Compliance rates were almost identical in the two treated groups [i.e., three droponts in each group], and were 30 to 40 per cent better than the rate in the non-treated patients [i.e., 22 dropouts]," Dr. Bigger said. The study, he noted, was carried out in the suburban office of a general ophthalmology group practice.

Noncompliance is also likely to occur in cases of chronic, asymptomatic illness requiring long-term therapy, the benefit of which is not immediately apparent or is accompanied by side effects, and where discontinuing therapy causes no immediate effect, Dr. Bigger said. "In addition, the illness itself may also diminish the patient's capacity to comply."

Dr. Bigger also noted that, in general, the more a therapeutic regimen

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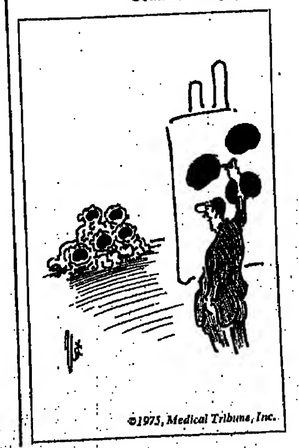


Current Opinion

On the Crisis of Access

By DR. STANLEY S. BERGEN, JR.
President
College of Medicine and Dentistry of New Jersey

[The following comments have been excerpted from a keynote address by Dr. Bergen at a recent Colloquium on Primary Care, "Understanding Tomorrow's Medicine Today," held in Newark—Ed.]

J. HERBERT FILL IN A RECENT MONOGRAPH has noted, "The true concept of cure has been lost. More and more people do not live healthier lives; they are merely prevented from dying. There is indeed a technical but no human conception of what health is". He feels that we are "self-defeating" by our "single-minded insistence on purely external solutions". He is obviously urging a broader rather than fragmented approach to total health and the well-being of the whole person. Medical and/or mental care cannot be separate from health care—environment, life style and personal responsibility for the maintenance of health and prevention of illness.

Political leaders, health economists, practicing physicians, medical educators, the lay public—all have been able to identify the problems of the delivery of health care. Comedians joke about the inaccessibility of physicians on Wednesday afternoons or weekends. The idolized TV physician is available to millions of viewers and yet, his counterpart cannot be identified in most cities of our country.

During the 1950's and 1960's, the trend in medical education was towards specialty orientation. This orientation took place initially in the large medical centers where the expansion of knowledge required that individual specialty practitioners be available in order to adequately address the issues of acute in-hospital care. Physicians began grouping in multi-specialty groups so that a one-stop location could be provided for the full spectrum of health care needs of a large community. Hospitals ascended as the focal point for the delivery of health care and the emphasis within medical schools was upon educational programs that were categorically developed and specialty oriented. Funding from the National Institutes of Health and other federal programs encouraged the development of the specialty programs . . . while the emphasis upon general practice and generalists seemed to diminish.

Manpower Distribution

Janeway compared Great Britain and the United States concerning the distribution of physician manpower between general practitioners and specialists . . . The ratios are . . . 1 specialist for every 2.75 general practitioners in the United Kingdom, and 4 to 1 in the United States.

With cost of health care rising rapidly, Janeway notes that the impact of such physician distribution affects the cost. In 1970 each individual in the United Kingdom spent an average of $107.00 on medical services while in the United States during the same period these services cost $390.00. The cost per practicing physician in the United States, therefore becomes $286,740.00.

We are all aware of the tremendous inflation of health care cost between 1960-1975: During this period, expenditures for health increased from $26 billion to over $104 billion annually while public expenditures for health care rose from $6.4 billion to $41.3 billion. The health industry increased from 2.5 million workers in 1960 to almost 5 million in 1974. Last year, the health industry provided over 1 billion physician and dentist visits and over 30 million short-term hospital services.

Increased Ambulatory Care

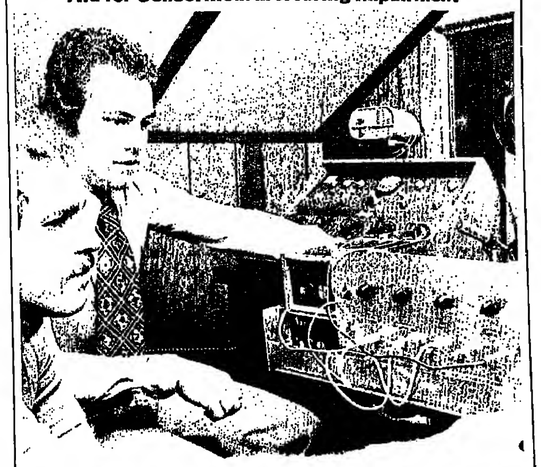
With the loss of primary care physicians from the cities, the number of ambulatory care and out-patient visits has grown from 223 to 562 per thousand population in the 20-year period from 1947-1967. In 1953, there were two out-patient visits for each in-patient admission while by 1967, the ratio had increased [to] 4 to 1. Many of these visits were provided by hospital clinics and similar structured facilities which often are unable to provide for an established patient-doctor relationship.

Despite the tremendous increase in health care expenditures over the last few years, there has been little evidence of improvement in the crude death rate in the United States or significant changes in the major causes of death. The major impact has come from public health measures, improved prevention and an awareness of the impact of various social issues on health rather than improved medical care for the masses. Yet . . . disproportionate funds are spent on illness vs. health maintenance and prevention.

Therefore, although our problems may seem to be access to facilities, personnel and financing, it may well be that the primary problem is one of access to adequate information.

Something has happened to our approach to the health care in the United States. While I would be the last to suggest that we return to the inadequate, ill-prepared and by today's standards, poorly educated general practitioner of the 1900's, it may be important for us to return to an era of willingness to care. We have probably entered an era in which dramatic medical advances that *benefit many* will be few and far between except possibly in cancer. The growth of applicable medical knowledge may plateau despite continued exciting advances in scientific biomedical knowledge. It behooves all medical practitioners, medical bureaucrats, public health officials and health professions educators to join in formulating the plan by which all citizens will have access to health care and become recipients of the benefits of medical knowledge gleaned for research of recent decades. All citizens must be provided with the information needed for sharing the responsibility for a healthy nation.

Aid for Sensorineural Hearing Impairment



New type hearing aid for those with sensorineural hearing impairment selectively amplifies consonants but not vowels, unlike conventional aids which simply amplify sounds. Adjusting fensibility model they developed are audiologist Paul Yanick, right, himself a sufferer from impaired hearing, and electronic engineering professor Harris Drucker, of Monmouth (N.J.) College.

We may have avoided one of the main problems of ethics facing the medical profession in the future, that is, the question of the accessibility of our patients to health information and the willingness that we express in sharing such information with our patients despite the fact that the sharing of this information may exert a significant impact on the patterns of health care, the traditional doctor/patient relationship and the economics of the profession and industry. Franz Ingelfinger has urged that medical ethicists and physicians communicate more closely with each other on problems of medicine and medical practice. I would add the need to include the public in such discussions because I believe the central issue of health ethics today is access to information. Not merely the "right to know" concept concerning what has been done for a patient, the diagnosis, prognosis and options but also what role the patients can and should play in their own health care. There is no doubt that professionals must continue to make the primary decisions towards the care of individual patients and decisions concerning those options available to the patient in the delivery of health care. However, we must no longer make these decisions alone but rather must listen to the needs as expressed by our patients and citizens.

Symptom Not the Disease

Society's decision-making can be effected by the professional but only if society is well informed of its choices and the effect that these choices may have on other options and other areas requiring fiscal, personnel and natural resources.

I believe that the apparent lack of adequate primary health care is a symptom and not the disease. We have neither shared with the public the decision making process, the allocation of resources and the determination of priorities nor have we provided the information necessary for the public to assume a role in the decision making process and take responsibility for a measure of their own health care, health maintenance and improved well-being. Actually, if correctly used, we may have adequate health care potential. Unfortunately, the patient has been overwhelmed by the emphasis on the quality of care received from the specialists and the professional has been impressed with status, finances, hospital privileges, etc., factors which have forced issues in the opposite direction. We have created a two-class system in the United States: the rich vs. the poor, the hospital vs. ambulatory care, primary care vs. specialty care and the informed vs. the uninformed.

System Must Change

Financial incentives, educational systems, patterns of behavior and expectations all must be changed for, at present, they work against the provision of general health care for all our citizens. They all favor decisions which virtually preclude good primary care, maximum hospital usage, short hospitalization, appropriate physician visits and delegation of responsibility to non-physicians. All physicians must return to a posture of caring for people rather than one of providing care alone.

In the context of team health care, I can imagine that different types of physician providers may function effectively as long as they maintain equal status, access to hospitals and patients. The specialists, the generalists and the physician extenders should all be part of the effort to provide the health care system with adequate, competent professionals. Each should function upon a level of equal status as part of the total effort. Primary care must become an accepted part of the comprehensive delivery system, act as the resource of

Continued on page 15

The Only Independent Weekly Medical Newspaper in the U.S.

Medical Tribune
and Medical News
Published by Medical Tribune, Inc.

In Medicineland, U.S.A.

Child of the pure unclouded brow
And dreaming eyes of wonder!
Though time be fleet, and I and thou
Are half a life asunder,
Thy loving smile will surely hail
The love-gift of a fairy-tale.

DEAR ALICE:

I have another wondrous fairy-tale to tell. In our country we have a special bureau to regulate drugs. They decide which drugs the doctor may have and which drugs he may not have. They also decide which drugs may be used without the doctor's prescription and which, because of their potency or problems in their use, require a doctor's prescription.

Now, Alice, you may begin to understand some of my confusions in our medical wonderland here. For years this bureau, the Food and Drug Administration, has fought to have essential food elements such as vitamins declared as food at one dosage level and as a drug at another. Our courts decided they could not do this with the vitamins found in oranges, lemons and limes. But verily they are able to require a prescription for another vitamin, vitamin A, when it is to be taken in an amount equal to or even less than what is provided in a slice of liver.

Recently I visited in Washington and in my naivete I inquired as to recent changes in the package insert instructions for doctors in the most potent drug used to lower the sugar in the blood of those who have too much—we call them diabetics. It was recently up-dated, I was told. Being of simple faith, I went out and bought some packages of this potent substance—insulin. To my astonishment, there was no doctor's package insert with the usual warnings of side effects, contraindications, none of the official basic and background information required for drugs too potent to be bought without a prescription.

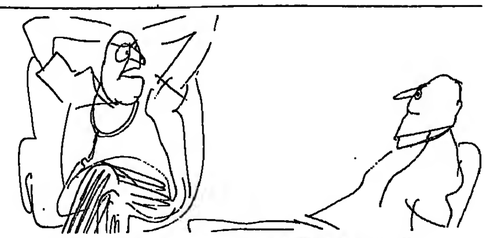
Now, insulin can cause coma and can kill. In fact, until recent advances, it could kill without leaving a trace. But the requirement set for vitamin A prescription is deemed to be unnecessary for insulin. Anyone can buy it over-the-counter. Ah, I thought, perhaps it is because it is an *old* drug. No. Perhaps it is because it is *so essential* and is used *so frequently* by patients. No. Digitalis is an old drug and digitalis is a life-saving drug, and it may be used for a lifetime, but digitalis requires a prescription.

My head reels. Of course, consistency is the hobgoblin of little minds.

Why the difference, dear? Well,

Thy loving smile will surely fade
To see how "Wonderland's" rules
are made.

A.M.S.



"You know what I say when they say 'What's up, Doc?' I say, "None of your goddamn business!"

Restraints...and Scientific Inquiry

TWO MONTHS AGO, a thoughtful and balanced editorial on "Freedom of Inquiry" appeared in an issue of *Science*. The author, Dr. DeWitt Stetten, Jr., Deputy Director of Science at N.I.H., pointed out that the first amendment to the Constitution "explicitly forbids the Congress from abridging the freedoms of speech and the press," yet abridgement does occur, from time to time, "subject to the test of a real and present danger."

Dr. Stetten observed that freedom of inquiry is of importance comparable to that of speech and the press. Curtailing the freedom of inquiry has proved disastrous in past and present historical periods. Anxieties—and more than that—have been voiced currently about inquiries into the genetic contributions to intelligence; experiments that may be performed on informed adults, on minors, on fetuses, and on prisoners; screening infants for genetic defects; interference in human conception, as by "artificial insemination, abortion, cloning, in vitro fertilization or the use of surrogate mothers;" genetic engineering. Dr. Stetten suggests that in these and like problems "we treat freedom of inquiry as we have learned to treat freedom of speech—that is, agree to abstain when there is a real and present danger." The dangers he refers to are those to "the community, the environment, or the individual."

The editorial evoked responses agreeing and disagreeing with Dr. Stetten. It is apparent that there are scientists who find it difficult to accept any limits to the absolute right of free inquiry. Such a viewpoint was expressed by a few investigators quite vehemently at the international Asilomar conference convened last February to consider the hazards of genetic manipulation by recombinant DNA molecules. But the conference did more or less define what was considered permissible and what was not by drawing up a list of recommended precautions to be taken by investigators working in the field of genetic engineering.

If investigators demand an unrestricted right to the freedom of inquiry, they must act with responsible *self* restraint in the interest of society. Scientists must be sensitive to real and present dangers to the community, the environment and the individual—and must also point out when such dangers are truly not present.

LETTERS TO THE TRIBUNE

A Service in Malpractice

I read with dismay the comments of Dr. Sidney A. Bernstein (MT, Sept. 24). Dr. Bernstein accused me and my service of contributing to the malpractice problem. This allegation arose from a foundation of ignorance for Dr. Bernstein has no understanding of the nature and function of our organization, nor did he bother to inquire.

National Medical Advisory Service is a physician-run screening panel designed to evaluate medical liability cases for defense and plaintiff attorneys. Fifty per cent of our cases come from defense council. Very often we can successfully assist our colleagues; at times we cannot. At least 60 per cent of the cases which we evaluate for plaintiffs are determined to be without merit. We have been remarkably successful in dissuading prosecution in those cases. This is our most valuable function. Without a service such as ours the medically naive attorney will grope aimlessly, file suit needlessly and be driven underground into the arms of the few unscrupulous medical people of whom we are all aware. Lawyers need competent advice if this trend is to be stopped. Our introductory letter, which Dr. Bernstein found distasteful, is one way to alert the attorney that competent medical advisors are available.

I am afraid that it is those physicians who recoil at the word "malpractice" and hide when a lawyer calls who have most fueled this problem. Plaintiffs and their attorneys have no medical expertise. We well-trained, ethical physicians must willingly review their problems if we are to return fairness to medical litigation.

RONALD E. GOTS, M.D., Ph.D.
Medical Director
National Medical Advisory Service
Washington, D.C.

Fetal Music

Please accept my thanks and congratulations on Dr. Sackler's series [on von Karajan in] "One Man . . . and Medicine." Being a member of Los Angeles Doctors Symphony Orchestra, I am very sensitive to the tranquilizing effects of classical music.

I wonder how you feel about our rock and roll with its noise pollution over ninety decibels. It has been my experience, though limited, that the music of Brahms, especially the First Symphony, closely resembles the pulsations found in the intrauterine environment of the foetus.

May I suggest, perhaps, that an entire symphony could be written based entirely on the flow of energy, fluid and neuromuscular movement of the human body. Has this ever been done? It would of course, have to include the Neonate and his struggle onto full maturity. Finally, I feel that the car radio has contributed a great deal to distractive and detached environs, causing many accidents.

A. M. GROSSMAN, M.D.
Beverly Hills, Calif.

Hyperlipoproteinemia

Frances Goodnight's article (MT, Oct. 15) reviewing my recent presentation before the American Chemical Society was lucid and accurate in all respects. The editorial about it, unfortunately, contained several substantive inaccuracies.

I pointed out that therapeutic responses in the homozygous form of familial hypercholesterolemia is disappointing while therapy in *other forms* of hypercholesterolemia is, while not totally satisfactory, rather successful. The editorial had this point reversed.

I pointed out the theoretical possibility that an agent that increased the rate of uptake of lipids into peripheral tissues—if it also increased the uptake into the arteries—might accelerate atherogenesis while lowering plasma lipid levels. The editorial clouds the point, implying that lowering plasma lipid levels might somehow *per se* hasten the development of atherosclerotic lesions. Undoubtedly, the reverse is usually true.

I carefully pointed out that my presentation was speculative. The editorial incorrectly refers to "newly available evidence" that I cited as though it bore directly on the feasible but undemonstrated paradox I outlined. There is in fact no evidence to my knowledge that any agent currently in use or currently under investigation actually causes the kind of dissociation about which I was speculating. The evidence from cell culture studies provides a basis for speculation but it would be unfortunate if your readers were left with the impression that the *probability* of encountering such a dissociation is very great. It probably is not.

A reference to Frances Goodnight's piece, which provided the background and a proper perspective, was omitted from the editorial.

DANIEL STEINBERG, M.D., Ph.D.
Professor of Medicine and Head,
Division of Metabolic Disease
University of California, San Diego

An open letter to the doctors of America

Subject: **The all-important physician-patient relationship**

Dear Doctor:

We must and will do something about it.

The science and art of medicine has reached its most advanced state but the all-important physician-patient relationship is plunging to an all-time low.

We must do something about it.

The establishment of "cost-effective" control rather than "therapeutic-effective" practice is part of the drive towards the government's dominance, if not takeover, of medicine. Physicians personally, and the medical profession generally; medicines specifically, and diagnostic and other procedures generally, have become a target for governmental attacks as a result of the pressures generated through sensation-seeking consumerism and political expediency.

Patient regimens are too often disrupted, medical advice disregarded and medications neglected. Early diagnosis of essential conditions is being placed in jeopardy and early treatment delayed.

We must do something about it.

Medical Tribune has addressed these issues editorially. Medical Tribune has encouraged the mobilization of official bodies of medicine. It has reported extensively on constructive efforts by *ad hoc* committees of physicians. We have discussed these problems at great length with responsible consumer leaders, leaders in all fields of medicine, and with a whole gamut of government officials.

More is needed.

Medical Tribune has developed and is introducing an innovation in patient education to help rebuild and sustain the all-important physician-patient relationship. Medical Tribune has prepared a series of supplements for use in physicians' waiting rooms, clinics, and hospitals, entitled THE GOOD DRUGS DO. Each supplement is prepared by an outstanding leader in one of the fields of medicine. Each supplement is written so that the patient can understand it. Each seeks to advance the goal of an informed patient, a cooperative patient, and a patient confident in his physician's practices, medicines and recommendations. The waiting room patient supplement, THE GOOD DRUGS DO, will be coming to you as a section of Medical Tribune.

THE GOOD DRUGS DO patient supplement in Medical Tribune seeks to do something positive about the physician-patient relationship.

THE GOOD DRUGS DO supplements prepared thus far consist of a general introduction by Dr. Louis Lasagna, covering the broad advance made by therapeutic medicine in the Golden Age of Therapeutics. THE GOOD DRUGS DO individual supplements then go on to take up Depression, Hypertension, Nutrition and Vitamins, Alcoholism, Diabetes, Arthritis, Psychoses, Antibiotics. Each subject supplement is prepared by an outstanding authority in the field and addressed to patients.

Please remove THE GOOD DRUGS DO supplements from coming issues of Medical Tribune and put them in your waiting room.

You can help us help your patients by making this essential material available to them and by advising us as to how we may make improvements in your and your patients' interests.

We can do something about the all-important physician-patient relationship.

Sincerely,

International Publisher

Combined Drugs Held Useful in Relief of Pain

Continued from page 24

tion or having engaged in drug abuse.

Various combinations of imipramine, chlorimipramine, or trimeprimine with laevomepromazine or haloperidol were administered. Improvement was observed in 82 patients: 22 were without pain and analgesics could be discontinued, while in 60 pain was reduced and the intake of analgesics could be lowered.

Treatment had to be discontinued because of somnolence or arterial hypertension produced by laevomepromazine in 10, and urine retention in two patients due to imipramine. Haloperidol has since been substituted for laevomepromazine.

The best results were obtained in cases of postherpetic neuralgia and in lesions of the brachial and lumbosacral plexus. Generally good results were noted in patients with painful neuro- and polyneuropathies, in trigeminal neuralgia, in degenerative diseases of the skeletal system (except intervertebral disc hernia), in traumatic pains of the locomotor system and in cancer.

One patient with mononeuritis multiplex, one with locomotor injuries and seven with degenerative skeletal disorders, chiefly intervertebral disc hernia, did not respond.

Dosage Schedule

On the basis of this experience, a dosage schedule for outpatients has been worked out in which 25 mg p.o. imipramine or chlorimipramine are given three times daily with haloperidol, starting with 0.5 mg daily and carefully increased to 1 mg two to three times daily.

Inpatients are given chlorimipramine in i.v. infusions of 25-50 mg in 5 per cent glucose during two to three hours daily, shifting to 25 mg p.o. three times daily after a week, combined with haloperidol in the same dosage as received by outpatients.

If improvement is observed, the combination is continued for several weeks, Dr. Kocher said. Elderly patients should not receive more than 1.5 mg of haloperidol daily, he warned. If, as rarely happens, a Parkinson syndrome appears, an antiparkinson drug should be added.

The clinic has used this schedule in 19 patients to date, with an improvement in all but one who suffered from a degenerative disease of the skeletal system underlying a neurotic condition.

The effectiveness of the two psychotropic drugs can probably be explained by the wide-spectrum central and peripheral action they provide, Dr. Kocher said. The therapy alters the perception of pain, leading to its "depersonalization." Patients sometimes say, "I still have the pain but it no longer hurts."

The combination is also more effective in interrupting the pain-anxiety-depression-pain cycle than either thymoleptics or neuroleptics alone. One can speculate that these drugs also interfere in some way with pain-producing substances, he added.

Throngs look on in Mexico City as Danes defeat Mexico's "Aztecs" in World Women's Soccer Final.

U.S. Women's karate champ Joy Turberville, defending herself.

TRIBUNE SPORTS REPORT

Women Effectively Engage In Rough Contact Sports

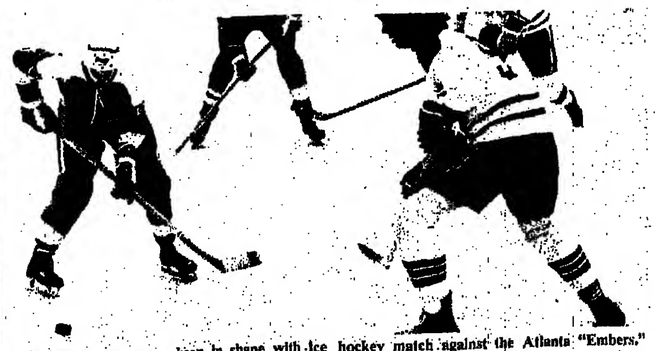
THE OLD IDEA that "frailty thy name is woman" bites the dust in these glimpses of women athletes in contact sports. As Dr. Thomas McLaughlin, Professor of Orthopedic Surgery at Case Western Reserve School of Medicine, has pointed out in an earlier issue (MT, Oct. 1, 1975), the relegation of women to the sidelines is more a cultural trend than a physiologic imperative. Apparently, women can don cleats and pads as well as men, and as Dr. McLaughlin also suggested, it's just as easy for them to break a nose or a bone or a tooth.

Collegians vie in old favorite.

They call it "sock her."

Dallas "Bluebonnets" vs. Los Angeles "Dandelions" in pro football.

Reverse stick tackle in field hockey.



Delta Airline hostesses keep in shape with ice hockey match against the Atlanta "Embers."

New Microsurgical Technique Reverses Most Vasectomies

Continued from page 1

anastomosis and that a non-strictured vasovasostomy can only be accomplished with confidence by microsurgical operating techniques," he stressed.

Dr. Silber, who is chief of urology at the Veterans Administration Hospital here and Assistant Professor of Urology in the University of California School of Medicine, San Francisco, reported that in the Australian trials, where the vasovasostomy has been under clinical study for four years, the procedure has been successful in 15 of the first 20 patients, a 75 per cent success rate. His own clinical trials, following three years of animal studies, were started eight months ago, and most were performed in the past five months, Dr. Silber declared. In very early follow-up, two of ten patients have impregnated their wives. Dr. Silber predicted that the success rate in the American series would rise substantially with further follow-up.

Key to Method

In the surgical method developed by himself and Dr. Earl Owen, Prince of Wales Hospital, Sydney, Dr. Silber said, the key lies in achieving an accurate mucosal approximation when reanastomosing the lumens of the transected vas deferens. Following vasectomy, he noted, the lumen of the vas distal to the ligature is about .25 to .33 mm in internal diameter, and the lumen proximal to the ligature is about .50 to .75 mm in diameter. In the vasovasostomy, performed under a dissecting microscope, a finely polished jeweler's forceps is used to dilate the lumen of the distal vas, thus creating lumens of approximately equal diameters. A mucosal anastomosis is performed, using fine nylon. Heavier sutures create the risk of sperm leakage and granuloma formation, Dr. Silber noted. A separate muscularis layer is then closed.

"This latter point is of critical importance," Dr. Silber stressed, "since a normal condition of peristalsis is essential for propulsion of the sperm from the epididymis at the time of intercourse."

He added that although "a great deal of practice is necessary to perform these micromanipulations," most surgeons can become adept after about three months of intensive training.

"Postoperative studies of the patients' semen," Dr. Silber reported, "showed no evidence of immunologic damage. Instead, it appeared that the sperm present at the time of vasovasostomy were all old and had died from autolysis. After three months, these old sperm, remnants of the previously obstructed state of the vas, were replaced by healthy spermatozoa whose genesis presumably came after successful release of obstruction. Of course, it would take three months for these new healthy sperm to appear in the ejaculate."

In an interview, he said that the duration of the vasectomy did not appear to correlate with the success or failure of the reversal procedure.

"The vasectomy of longest duration in our series was 15 years, the shortest under two years. The average time was about four or five years. The most important factor in success, we believe, is the perfect surgical anastomosis."

Sperm Studies

He disclosed that his team is doing electron microscope sperm studies, and "our preliminary evidence suggests that, on an anatomic basis, the immunologic barrier is intact in the vasectomized male. Dr. Owen's group is doing serologic studies and thus far finds no correlation between success of the vasovasostomy and sperm antibody titer."

Dr. Silber ended on a cautionary note, however: "Our advice to any male is, don't have a vasectomy unless you're absolutely certain that you don't want it reversed. We [surgeons] can't make any guarantees. On the basis of our very early data, the best we can promise at present is a 60 per cent reversal rate. That figure will go up, undoubtedly, but any male contemplating a vasectomy had better remember that 100 per cent successful operations to reverse the procedure—100 per cent successful operations in anything—don't exist."

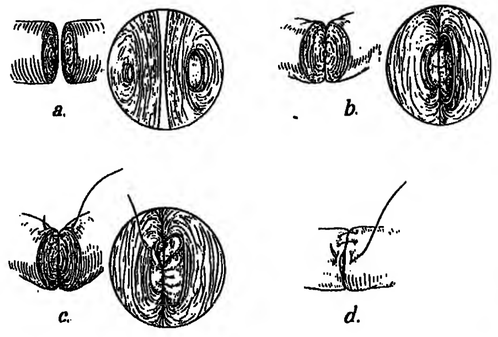
In New York, a leading authority in fertility studies said that he was not persuaded by Dr. Silber's claim that an immune response has not been shown to be a factor in the success or failure of vasovasostomies.

"Dr. Silber is reporting a series of 30 cases overall, a very small sampling for his conclusions," said Sidney Shulman, Ph.D., Director of the Sperm Antibody Laboratory at New York Medical College, and Research Professor of Urology and Obstetrics-Gynecology. "It is entirely possible that he may have hit on a group of patients the majority of whom don't have an immune response to the vasectomy.

"It must be remembered that a man who has sperm antibodies would not necessarily have an abnormal semen picture. The reason is that the antibodies don't meet the sperm cell until ejaculation. If the antibody concentration is not too high, and if they're not too avid, they may react slowly and continue their reaction inside the female. That is not the kind of evidence that would show up right away or under ordinary microscope examination," Dr. Shulman continued.

Questions Raised

Acknowledging that Dr. Silber's procedure to minimize damage to the vas deferens could make for easier sperm passage, Dr. Shulman insisted: "When he says there's no immunologic effect, I don't think he has measured it. He reports that studies under the electron microscope show no evidence of immunologic damage. I don't know what damage one would expect to see. What was the evidence that he failed to find? I would never think of using the electron microscope as a method of looking for immunologic impairment... Further, Dr. Silber hasn't cited the recent reports suggesting that a reasonable percentage of men with vasectomies do develop high titers to sperm antibodies."



Schematic presentation (above) of vasovasostomy developed by Dr. Silber shows (a) Transected ends of vas deferens seen grossly (left); in enlarged view (right) as seen under dissecting microscope, distal and proximal lumens are clearly of different diameters. (b) In enlargement, suturing of lumens has begun. (c) Transected ends of the muscularis of the vas are approximated; in microscopic view, mucosal suturing is being completed. (d) Anastomosis of the muscularis is almost complete. In photograph (below), suturing of lumens has been completed and the surgeon is about to begin final suturing of the muscularis.

Meditation . . . Without Metaphysics

Continued from page 1

tients with ischaemic heart disease."

The Technique

"(1) Sit quietly in a comfortable position.

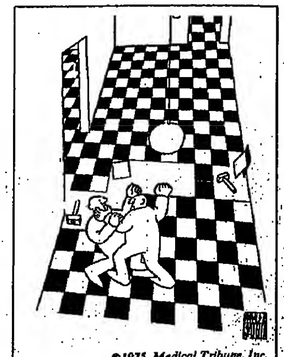
(2) Close your eyes.

(3) Deeply relax all your muscles, beginning at your feet and progressing up to your face. Keep them deeply relaxed.

(4) Breathe through your nose. Become aware of your breathing. As you breathe out, say the word "one" silently to yourself. For example, breathe in . . . out, "one"; in . . . out, "one"; etc.

(5) Continue for 20 minutes. You may open your eyes to check the time, but do not use an alarm. When you finish, sit quietly for several minutes at first with closed eyes and later with opened eyes.

(6) Do not worry about whether you are successful in achieving a deep level of relaxation. Maintain a passive attitude and permit relaxation to occur at its own pace. When distracting thoughts occur, ignore them and continue repeating "one". With practice, the response should come with little effort. Practice the technique twice daily, but not within 2 hours after any meal, since the digestive processes seem to interfere with the elicitation of anticipated changes."



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Current Opinion

On the Crisis of Access

Continued from page 9

first contact, consider the patient's total needs and review the social, physical, mental and environmental impacts upon the individual. A composite solution to health problems would then evolve including imparting to the patient the information necessary to cooperate, to participate and to contribute to the individual's health care and well-being.

The crisis of access is not merely an access to health care but access to caring physicians and other health professionals and a willingness of all those professionals to provide access to information. The primary care physician of tomorrow will be a better educated, better scientifically equipped physician who must turn considerable energy towards the counseling of the patient.

With the advent of the Health Planning Act of 1974, 93-641, there is the opportunity to develop networks of primary care facilities without the loss of specialty care located at centralized or regional hospitals. The evolution to such a system must be incremental in order to gain acceptance from both provider and consumer and invoke upon the current system, the least disruptive changes. A National Health Plan can lead to the orderly evolution of our system and provide access for all citizens to adequate health care and the expertise of providers within that system. Education is needed on all levels of consumer programs so that we will replace fragmentation with a set of accepted and established goals and a system that unifies the health care delivery potential of our country into a mechanism that will assure access for all to facilities, professionals, financing and information.

Greater effect may come from a total system of health maintenance which includes the social, environmental and medical factors. Lelonde noted that human biology, environment and personal decisions concerning lifestyle may be as important if not more than improved medical care.

All students now in medical school must learn the multiple roles that they shall play in the future, not only as deliverers of medical care but as organizers of health care delivery programs for their patients. Primary health care is a large aspect of such a program. The crisis of access is a crisis of organization, information and motivation. Health professions educators must assume the leadership role.

Halt Baby Food Sugar?

Medical Tribune Report

WASHINGTON—Some 370 health professionals and health students have signed a petition sponsored by the Center for Science in the Public Interest, urging the F.D.A. to halt production of baby food desserts and to demand that manufacturers remove added sugar from other products. Some desserts, it was disclosed, derive 27 to 44 per cent of their calories from added sucrose. Other products are also "embarrassingly high" in added sugar, said Dr. Michael Jacobson, codirector of C.S.P.I.

Tribune Economic Analysis

Heading Off The Danger of High Oil Prices

BY ELIOT JANEWAY
Consulting Economist

The OPEC 10 per cent increase on oil (already at $10 a barrel) will speed erosion of the entire world economy. The chance of heading off the danger hinges on America's resolution and resourcefulness in undoing OPEC's latest outrage.

Forcing the withdrawal of the 10 per cent increase will not be enough. Nothing short of a rollback to a $7 price base —as a starter—will release the brakes now holding the economy back.

The prospect of splitting OPEC's facade of unity, and forcing price cuts out of its weaker sisters, has been discounted by some as a lost cause. But the admitted financial distress of a growing list of OPEC members is now making this a practical proposition.

Indonesia is the most attractive candidate for the role of price-cutter. Her borrowings make Iran's seem moderate. She is running six months behind on settling up her import bills and her oil isn't moving.

The American economy would get a double benefit from selecting Indonesia as the agent for splitting up OPEC. Indonesia is a major oil supplier for Japan, which has been hurt by the OPEC gouge even more than America. Japan has been restraining herself from dumping her backed-up production onto the American market. Persuading Indonesia to assure Japan that cheaper oil is coming back is one sure way to protect America's shaken industrial communities from this shock.

Ask Janeway

Events have demonstrated the need to have my mother admitted to a nursing home where she could receive proper attention. Although she is still active and alert, we are both concerned about the transfer of her assets to me. The current depressed economic conditions and when to do this is our problem. Is there any advantage in when you do this?

Upstate New York, M.D.

The decision depends upon the size of her holdings. If they are large enough to be taxable as an estate, they should be transferred as soon as possible because the gift tax is lower than the inheritance tax. This strategy is betting on at least two years of life expectancy. Remember that assets transferred to an heir within two years prior to the death of the owner are deemed transferred in anticipation of death and therefore are taxed to the estate, not the recipient.

The tax code offers another helpful option—buying the "flower bonds" the Treasury offers as an inducement for aging taxpayers.

Send your questions on finances, investments, taxes to Janeway, MEDICAL TRIBUNE, 880 Third Avenue, New York, N.Y. 10022.

First Month Held 'Critical Period' In Compliance

Continued from page 7

"interferes with or alters the patient's daily pattern of living, the less likely it is to be followed." A realistic schedule, worked out with the patient himself, may be better than an "ideal" one which he may not follow, he added.

The use of calendar-dose packaging, sustained release medications, and fixed drug combinations are also helpful. For patients who still fail to take their medication, Dr. Bigger recommended having them bring their medication to the office for personal inspection.

Psychologically, noncompliant patients are typically those who show little concern for their health, who do not believe in the benefit of the therapy or the office visit, and who do not understand physician instructions, he said, adding that economic factors also play a part in this behavior.

However, the physician is responsible for noncompliance when he fails to explain the patient's situation clearly, or is hostile, argumentative, or demonstrates uncertainty regarding therapeutic efficacy, Dr. Bigger said.

To counteract these tendencies, he urged improved physician-patient relations as a general rule, a concerned and compassionate physician attitude, and clear-cut explanations to the patient.

Noncompliance in keeping appointments, Dr. Bigger said, is best handled by reviewing at the end of the day the record of patients who failed to show or cancelled without making another appointment.

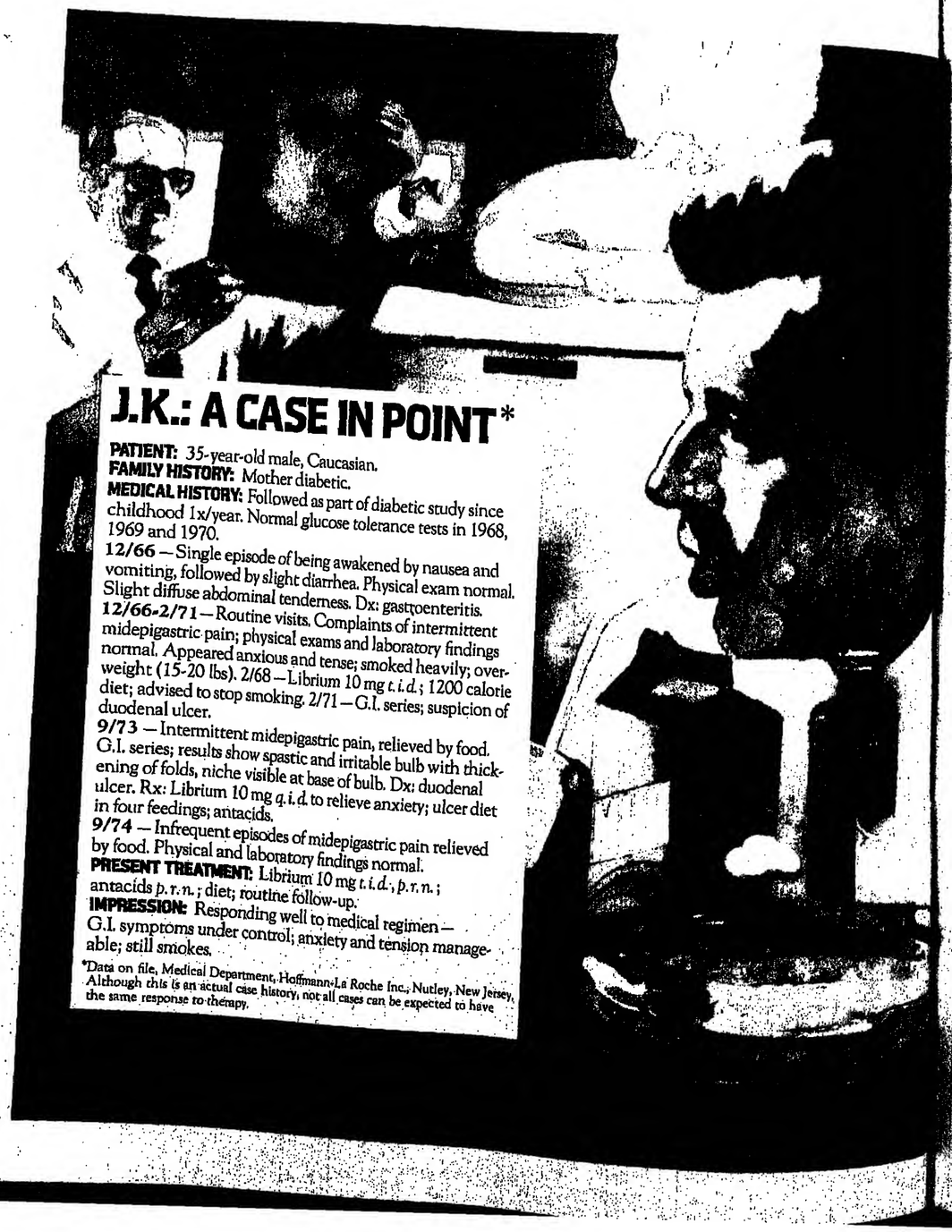
"The advantages of this day-to-day recall system are that it requires little additional time, as only selected patients will need to be recalled, and the efforts are not expended on patients who will keep their appointments anyway."

Sharks in Cancer Study

Patricia Byfield, Ph.D., U.C.L.A. Assistant Professor of Pediatrics, extracts "primitive" lymphocytes from a live shark in order to study their potential role in immune response to cancer.

LIBRIUM® AT WORK: (chlordiazepoxide HCl)

IN THE ANXIOUS PATIENT WITH ORGANIC GASTROINTESTINAL DISEASE



J.K.: A CASE IN POINT*

PATIENT: 35-year-old male, Caucasian.
FAMILY HISTORY: Mother diabetic.
MEDICAL HISTORY: Followed as part of diabetic study since childhood 1x/year. Normal glucose tolerance tests in 1968, 1969 and 1970.
12/66 — Single episode of being awakened by nausea and vomiting, followed by slight diarrhea. Physical exam normal. Slight diffuse abdominal tenderness. Dx: gastroenteritis.
12/66-2/71 — Routine visits. Complaints of intermittent midepigastric pain; physical exams and laboratory findings normal. Appeared anxious and tense; smoked heavily; overweight (15-20 lbs). 2/68 — Librium 10 mg *t.i.d.*; 1200 calorie diet; advised to stop smoking. 2/71 — G.I. series; suspicion of duodenal ulcer.
9/73 — Intermittent midepigastric pain, relieved by food. G.I. series; results show spastic and irritable bulb with thickening of folds, niche visible at base of bulb. Dx: duodenal ulcer. Rx: Librium 10 mg *q.i.d.* to relieve anxiety; ulcer diet in four feedings; antacids.
9/74 — Infrequent episodes of midepigastric pain relieved by food. Physical and laboratory findings normal.
PRESENT TREATMENT: Librium 10 mg *t.i.d.*, *p.r.n.*; antacids *p.r.n.*; diet; routine follow-up.
IMPRESSION: Responding well to medical regimen — G.I. symptoms under control; anxiety and tension manageable; still smokes.

*Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley, New Jersey. Although this is an actual case history, not all cases can be expected to have the same response to therapy.

CLINICAL ANXIETY AND THE G.I. PATIENT

After the ulcer patient's acute episode is under control, your counseling and reassurance about the status of the ulcer are often enough to allay anxiety. In some patients, however, excessive anxiety and emotional tension may interfere with medical management. When this occurs, Librium (chlordiazepoxide HCl) may be a beneficial adjunct.

Librium offers a high degree of antianxiety effectiveness, with relatively few side effects, for the ulcer patient. In addition to a long clinical record of prompt and effective action, Librium has an established safety record and an excellent record of patient acceptance. In proper dosage, it usually helps calm the overanxious patient without interfering with mental acuity or general performance. However, as with all CNS-acting drugs, patients should be cautioned against hazardous activities requiring complete mental alertness. Librium is often used concomitantly with certain specific medications of other classes of drugs, *e.g.*, anticholinergics and antacids. Of course, Librium therapy should be discontinued after anxiety has been reduced to tolerable levels.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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Nutley, New Jersey 07110

WHEN CLINICAL ANXIETY INTERFERES WITH PATIENT MANAGEMENT

LIBRIUM®
chlordiazepoxide HCl/Roche

5 mg, 10 mg, 25 mg capsules
FOR ALL THE RIGHT REASONS

HEW Considering Network of Centers for Amniocentesis

Continued from page 1

mester amniocentesis in more than 1,000 women, were described by clinical investigators and N.I.C.H.H.D. officials during a symposium held at the annual meeting of the American Academy of Pediatrics.

Dr. Theodore Cooper, Assistant Secretary for Health in the Department of Health, Education, and Welfare, told the symposium that "We can now say with virtual certainty" that this technique is safe and "can be applied to larger segments of the population without undue risk or hazard."

In a statement expected to have major impact, Dr. Cooper further declared:

"It is most appropriate for the Public Health Service, as a matter of policy, to foster use of amniocentesis by those women for whom it is indicated by educating both physicians and the public as to the availability and applicability of the technique and, based on results of this study, its safety."

PHS To Act

Attempts will be made by the Public Health Service to assure coverage for the procedure by both the private and the public medical insurance programs, he said.

The study compared the outcome of pregnancy in 1,040 women who had amniocentesis performed and in 992 matched controls who had no condition indicating a need for the procedure or who had refused it. Nine medical centers participated in gathering data for the collaborative project, which started in June, 1971, and was completed in June, 1975.

Since the primary purpose was to determine whether or not amniocentesis for prenatal diagnosis has adverse effects on the pregnant women or the fetus, the following findings were stressed in the evaluations:

- The rate of fetal loss from spontaneous abortion or stillbirth for the amniocentesis group was 3.5 per cent compared with 3.2 per cent for the controls —a statistically insignificant difference.
- Examinations of newborns showed no evidence of fetal injury that could be attributed to amniocentesis.
- A comparison of the infants born to control women and to women who had undergone amniocentesis revealed no significant difference in the incidence of congenital anomalies not detectable by amniocentesis.
- Follow-up testing of both groups of infants (primarily at ages 11 to 13 months) showed no significant differences between them as far as growth and developmental status were concerned, or in the incidence of physical or neurologic abnormalities.

Among the 1,040 women undergoing a total of 1,195 taps, 11 experienced vaginal bleeding and there were other relatively minor complications but no significant differences were observed between control and test women in complications of pregnancy, labor, or delivery. The rate of prematurity was essentially the same in both groups.

The great majority of the procedures (91.3 per cent) were performed for cytogenetic indications. Approximately half of these were done in women aged 35 or older. The remaining 8.7 per cent of the procedures were performed for detection of metabolic disorders.

Abortion Elected

A total of 19 chromosomally abnormal fetuses and 15 fetuses with metabolic disorders were identified. Additionally, 11 male fetuses were identified as having a 50 per cent risk of x-linked disorders such as hemophilia and Duchenne's muscular dystrophy.

Abortion was elected by 39 of the 45 women with fetuses at risk. Eight of the abortuses proved to have Down's syndrome, as did seven infants born to women in the control group.

Only six errors in prenatal diagnosis occurred, for an overall accuracy of better than 99 per cent. In three instances, the sex was misidentified (although not in tests specifically performed to determine sex), and in one case galactosemia was wrongly suspected in a fetus proving normal at birth. The errors considered serious were the failures to diagnose Down's syndrome in two fetuses.

Many of the investigators speaking at the symposium emphasized that the high levels of safety and accuracy shown in the study were achieved by experienced scientists working in well-equipped medical centers.

Dr. Cooper's statement called attention to the fact that "the limiting factor in expanding amniocentesis" is likely to be the availability of good laboratory facilities, noting that nearly all the analyses of amniotic fluids currently done in this country are performed in research laboratories where work has been supported by research grants.

This arrangement will not be feasible as amniocentesis becomes an accepted clinical practice, he pointed out, and therefore he believes "government involvement is probably necessary and appropriate" in gearing up a nationwide analysis capability.

Two Approaches

Two approaches are currently being considered by Dr. Cooper. One would be for the Public Health Service to establish a network of state or regional laboratories to perform the cytogenetic analyses, with research labs continuing to provide facilities for biochemical analyses.

The government, Dr. Cooper said, would provide "seed money" for space, equipment, and training of personnel at network facilities, which "ideally" would be established at pre-existing university centers.

Another alternative under consideration is to establish a "nationwide analysis capability under the aegis of the Center for Disease Control," to work with state and local institutions.

"In fact, a pilot project, in collaboration with a state health department and university, is already underway," Dr. Cooper said.

The centers participating in the N.I.C.H.H.D.-sponsored study were Children's Memorial Hospital (Chicago); Eunice Kennedy Shriver Center (Boston); Johns Hopkins University School of Medicine; Mt. Sinai School of Medicine; University of California at Los Angeles (Harbor General Hospital); University of California (San Diego) School of Medicine; University of Michigan School of Medicine; University of Pennsylvania School of Medicine; and Yale University School of Medicine.

For Education In Cardiovascular Disease

Groundbreaking ceremonies for "Heart House" were held by American College of Cardiology in Bethesda, Md., where new facility will contain the College's headquarters and serve as a national center for the continuing education of physicians and other scientists concerned with cardiovascular diseases. It is intended to supplement regional facilities and supply a centralized source for accumulation and dissemination of research findings. Participants in ceremony are (l. to r.) Sen. J. Glenn Beall (R–Md.), former ACC president Dr. B. L. Martz, Rep. Gilbert Gude (R–Md.), and Sen. Charles Mathias (R–Md.).

Ultrasonic Visualization Aids Differentiation of Jaundice

Medical Tribune Report

WINSTON-SALEM, N.C.—Ultrasonic visualization of dilated common bile ducts and biliary radicles is a safe and sensitive, noninvasive method of differentiating obstructive from nonobstructive jaundice, two Pennsylvania investigators told the 20th Annual Conference of the American Institute of Ultrasound in Medicine.

It is in fact the method of choice in imaging the biliary tract in jaundiced patients since noninvasive radiographic techniques result in insufficient opacification of the tract, according to Dr. Gordon S. Perlmutter of the Reading Hospital and Medical Center in Reading, Pa., and Dr. Barry B. Goldberg, Professor of Radiology at Temple University in Philadelphia.

Ultrasonography cannot, however, determine the etiology of the obstruction. But this is a minor drawback, explained Drs. Perlmutter and Goldberg, "since surgery is indicated in almost all cases of obstructive jaundice."

Linear Scan

In a six-month interval, 44 patients with jaundice were scanned on a commercially available gray scale unit which included a scan converter and TV display. "All scans were performed with a simple linear scanning technique with a minimum of sectoring and overwriting," the radiologists said.

In 16 cases, obstructive or extrahepatic jaundice was identified by the presence of dilatation of the biliary tract. Seven patients had recognizable dilatation of the common bile duct while the other nine were diagnosed on the basis of an enlarged gall bladder and dilated intrahepatic ducts.

"All cases diagnosed as having obstructive jaundice at ultrasonography were proven at surgery to have a mechanical obstruction," the investigators said. But "the cause of obstruction could only be reliably determined preoperatively in two cases with demonstrable common duct stones."

The radiologists warn that "great care is mandatory in performing and interpreting ultrasonograms," since portal and biliary structures may be confused. "It is necessary to establish the continuity of the dilated intrahepatic radicles with the common duct before the diagnosis of an enlarged common bile duct can be accurately made."

"In our experience, if the common bile duct is visualized at ultrasonography, it has been larger than 8 mm and therefore dilated. Only one exception to this has occurred to date, where a 6 mm common bile duct was visualized in a normal patient."

Inhospital Electrocutions

Medical Tribune Report

CHICAGO—A nationwide search for incidents of accidental electrocutions in hospitals, conducted by correspondence and personal observation, did not "yield any evidence to support the contention that there has been wholesale injury and death as a result of faulty electrical devices," Dr. John M.R. Bruner, of Harvard Medical School, told the American Society of Anesthesiologists.

Major Insurance Would Add Little to Health Care Costs

Medical Tribune Report

CAMBRIDGE, MASS.—Catastrophic health insurance (C.H.I.) for all Americans under 65 would add less than 2 per cent to present health care costs of some $900,000,000, according to an Arthur D. Little study of about 3,000,000 civil service employees and their families, currently covered by C.H.I.

The study, conducted for the Bureau of Health Services Research of H.E.W., found that the inflationary effect of such coverage would be "very minor" and produced no reason to set upper limits on national C.H.I.

The cost for such a program in 1975 would be $1,940,000,000 for some 184,000,000 Americans, the study predicted. The cost projection is based on findings that only a little more than four per cent of the population under 65 (i.e., 8,000,000 persons) is likely to have a catastrophic illness in a given year, the report stated.

No Major Dislocations

It also predicted "no major dislocation of available medical services," and found that "no single medical specialty, with the possible exception of psychiatry and nephrology, would feel the impact of C.H.I. acutely or experience significant new shortages."

Because psychiatric benefits comprise nearly a third of all catastrophic benefits to patients with medical costs over $3,000 a year, the report called for further study of proper criteria for this "contentious benefits issue."

With no enacted legislation to date on the problem of "financially devastating medical conditions," the study praised the Long-Rubicoff bill (S. 2513), which includes catastrophic health insurance provisions and underlying insurance for lower income persons, as "one of the most significant . . . proposals before the 93rd Congress."

George H. Harris, Ph.D., Stephan Peters, Ph.D., and Harry B. Wissman served as project team for the study. Dr. Barry Decker and Prof. Kenneth Arrow, the Harvard economist and Nobelist, also prepared a section of the final report. They noted that accuracy of the predictions in the study may be influenced by the fact that federal employees tended to be better educated, better paid, and in better health than the general population.

Clinical Trials

By Oldden

CAR CLINIC

Snow Tires: 1975

By DR. JOHN E. MCDERMOTT

Dr. McDermott points out advantages of the "hydrophile" as compared to steel-studded snow tires: shorter stops, less dangerous, no damage to road surfaces.

Semperit's M581, a "hydrophile" tire, improves stopping distance by attracting water rather than repelling it.

What's new in snow tires for 1975? Everything! First they are not "snow," but really winter or snow-, sleet-, ice-, or rain-type tires.

In an explosion of technical advances, the tire industry moved to meet the challenge of many state laws against steel-studded tires. The studs have been demonstrated not only to cause highway surface damage, but in high-speed driving conditions can be dangerous themselves.

Research has shown that when cars slip in the snow it is a factor of the *water* at the tire-snow surface; pathologic proof for an old clinical impression that some snow is slipperier than other snow. Manufacturers have sought ways of getting rid of this water, which has led to a variety of new winter tire designs.

The Sponge

Perhaps the most ingenious method of eliminating the water is to soak it up. Most rubber repels water, but, by polymer structure modification, rubber can be made to attract water. The result is the "hydrophile" tire. An example, the MR 581 by Semperit, demonstrates improved stopping distance while soaking up the water. It stopped in 50 feet on snow and ice a vehicle which under the same conditions took 85 feet to stop with ordinary snow tires and 120 feet with summer tires. As if to prove the principle, the company admits that at 33 degrees, just above freezing, the tire is not as effective—a result of excess water from the melting snow at that temperature.

The Squeegee

Still another way to achieve traction by eliminating snow surface water is to squeegee it away. Firestone used a computer to design tread which it claims maximally dissipates this water. Combining this new tread with wider tire design allows the new "Radial 500" to improve wet performance. Starting traction, however, is not as dramatically affected by this particular design as is running traction. Water entrapment is more of a problem in running than starting, so the squeegee type tires are probably better thought of as "rain" than "snow" tires.

Development of tires for the moon buggy for the National Aeronautics and Space Administration led Goodyear to compounds that remained flexible under freezing conditions. By remaining soft when regular tires are frozen stiff and behaving like wooden wheels, the Goodyear tire maintains traction. The use of cold flexible rubber allows a suction cup design which clings to wet road surfaces, greatly enhancing stopping distance over previous tires.

If you can't make up your mind about the new snow tires, then consider the new "chains." One type, called "Sur Tred," is made of molded plastic. When fitted over the tire in an easy snap-on operation, they perform like other chains but without the noise and vibration. The molded plastic shells can be manufactured in any color and can be obtained to match your car.

Psychiatrists Organize To Oppose Limitations On Electrotherapy Use

Medical Tribune Report

NEW YORK—A group of psychiatrists have organized the American Society for Electrotherapy to consider measures which would counter the activities of individuals and organizations proposing limitations on the use of electroconvulsive therapy.

Led by Dr. Leonard Cammer of New York and Dr. Gary C. Aden of San Diego, cochairmen, the group holds that legislative onslaughts and certain court actions in California, Michigan, Massachusetts and many local communities place medical judgment in the hands of laymen, and delay or deny proven, safe and effective treatment to those who desire such treatment.

The Naked Chicken Rears Its Ugly Head Again

We felt that we had made a genuine contribution to science by pointing out that when scientists get around to developing chickens without feathers, the chickens are no longer chickens but deserve a proper distinguishing name. Not long after that *David Brand* of the *Wall Street Journal* called them "preplucks," which seemed appropriate enough, considering economic conditions.

But the trouble with this business is that someone is always beating you to the punchline. In our issue of Sept. 10, at the conclusion of Dr. Sackler's astonishing interview with the Berlin conductor, Herbert von Karajan, regarding physiologic reactions to music, we read in that marvelous MT feature, "Epigrams—Clinical and Otherwise":

Plato having defined man to be a two-legged animal without feathers, Diogenes plucked a cock and brought it into the Academy, and said, "This is Plato's man." On which account this addition was made to the definition: "With broad flat nails."

That came from Diogenes (400-c325 BC), and flat nails and lantern aside, we figured that is where Woody Allen is getting his stuff. Running to our favorite bookstore, we grabbed his new bestseller, *Without Feathers*, from the shelves. And guess what we read as the opening bag?

'Hope' is the thing with feathers.
—Emily Dickinson

That racked us up. Or as people say nowadays, we were totalled. On recovery, we figured we might as well give you the whole thing as Emily saw it:

'Hope' is the thing with feathers—
That perches in the soul—
And sings the tune without the words
And never stops—at all.

Not a chicken at all. Not man. Just Emily.

One Before Bed

• From the *Psychiatric News*, Dr. Louise E. Light sends a clipping from a classified ad which reads: *Fresno—Psychiatric residences are avlb starting July 1, 1966* . . . Makes Dr. Light recall H. G. Wells' *Time Machine*.